Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3062AGC	A. BUILDING _____ B. WING _____	07/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINN'S DESERT HOME #2	478 PEARBERRY AVENUE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the State Licensure and complaint survey conducted at your facility on July 31, 2008. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 total beds. The facility had the following category of classified beds: Category 2, 6 beds. The facility had the following endorsements: Residential facility which provides care to persons with Alzheimer's disease The census at the time of the survey was six. Six resident files were reviewed and five employee files were reviewed. There were three complaints investigated during the survey: Complaint #11825 - was substantiated (see TAG #Y816) Complaint #14800 - was unsubstantiated Complaint #15387 - was substantiated (see TAG#Y850) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 000	Continued From page 1 identified:	Y 000		
Y 072 SS=E	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 5 employees completed documented medication management training every three years. Findings include: Interview On 07/31/08 in the afternoon, Employee #1 indicated employee files should contain Tuberculin screening test results and training proof.	Y 072		

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Y 072	Continued From page 2 Record Review The facility hired Employee #3 on 05/01/00. Employee #3's file contained eight hours of documented medication management training dated 01/17/04. The file lacked medication management update training after 01/17/04. The facility hired Employee #5 on 07/10/08. Employee #5's file lacked medication management training. Severity: 2 Scope: 2	Y 072		
Y 351 SS=F	449.222(2)(a) Bathrooms and Toilet Facilities NAC 449.222 2. Each residential facility that was issued an initial license on or after January 14, 1997 must have: (a) A flush toilet and lavatory for each four residents. This Regulation is not met as evidenced by: Nevada Administrative Code (NAC) 449.224.2 Members of the staff of the facility and their families who live at the facility shall be deemed residents of the facility for the purposes of determining the number of toilets, lavatories and tubs or showers the facility is required to have pursuant to NAC 449.222. Based on observation and interview, the facility failed to provide a flush toilet and lavatory for each four residents. Findings include:	Y 351		

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Y 351	Continued From page 3 Observation On 07/31/08 in the afternoon , the facility had five bedrooms with one bed in rooms #3, #4, and #5 (caregiver) and two beds in bedroom #2 and the master bedroom. The master bedroom contained a flush toilet and lavatory. A common hall bathroom contained another flush toilet and lavatory for bedrooms #2, #3, #4, and #5. However, having two residents occupy bedroom #2 and one each in bedrooms #3, #4, and #5 constitutes one flush toilet and lavatory for five residents. Interview On 07/31/08 in the afternoon, Employee #1 indicated bedroom #5 housed the live-in caregiver. Employee #1 indicated the facility would move another resident into the master bedroom. Severity: 2 Scope: 3	Y 351		
Y 816 SS=D	449.2732(3)(b) Protective Supervision NAC 449.2732 3. The administrator of a residential facility with a resident who requires protective services shall ensure that: (b) There is a written plan for providing protective supervision for that resident.	Y 816		

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Y 816	Continued From page 4 This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide a protective supervision care plan for Resident #7. Findings include: Record Review The resident was an 80 year old male discharged from the Gero-Psych unit at North Vista Hospital to Quinn's Desert Home #2 on 09/09/05. Resident #7 was discharged to the group home with three medications used to treat moderate to severe Alzheimer's type Dementia: Aricept, Namenda, and Razadyne. Resident #7 was admitted to North Vista on 08/31/05 on a Legal 2000 "because of psychosis and moderate to severe dementia." He was discharged on 09/09/05 with a diagnosis of Mixed Bipolar Disorder, Resolved Hypertension, and Poor Support System. On 09/09/05, an initial activities of daily living assessment signed by the owner of the group home indicated Resident #7 required protective supervision. A facility medical information report dated 09/09/05 indicated Resident #7 had a diagnosis of Bipolar Disorder/Mixed Dementia. A facility incident report dated 05/06/06 verified the allegation contained in this complaint: Resident #7 went for an unsupervised walk after dinner, the facility lost track of him, and the police eventually located the resident and took him to his wife's house. A resident transfer form dated 05/06/06 at 8:25 AM indicated Resident #7's wife signed the resident out of the facility permanently. Interview	Y 816		

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Y 816	Continued From page 5 On 07/31/08 at 10:30 AM, the administrator failed to indicate why the facility lacked a protective supervision care plan for Resident #7. Severity: 2 Scope: 1 Complaint #11825	Y 816		
Y 850 SS=D	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to notify and secure physician services as required to treat Resident #9's decline in activities of daily living (ADL) functioning. Findings include: Record Review An ADL form, dated June 2007 and signed by the facility's administrator, indicated the facility	Y 850		

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Y 850	Continued From page 6 considered Resident #9 a maximum assist for bathing, hygiene, toileting, and dressing; where as, the 05/15/07 ADL form indicated Resident #9 was a moderate assist for bathing, toileting, and dressing. The facility considered Resident #9 a minimum assist for hygiene on the same form. ADL charting dated June and July 2007 indicated Resident #9 was independent for ambulation for all of June 2007 and July 1-5, 2007. Beginning July 6, 2007 the charting indicated Resident #9 required assistance with ambulation. An incident report dated 07/09/07 indicated the facility discharged Resident #9 to a hospital due to shortness of breath, difficulty breathing, and congestion. Resident #9 had a recent history of congestive heart failure and chronic obstructive pulmonary disease. Interview On 07/31/08 at 10:30 AM, an interview with the administrator indicated the caregivers were giving Resident #9 sponge baths because the staff was afraid to give the resident showers due to the resident's unsteadiness and the possibility of not being able to lift her out of the tub if she sat down. The staff was assisting Resident #9 with transfers with a standby assist. The administrator indicated none of the aforementioned contrasts was reported to a physician. Severity: 2 Scope: 1 Complaint #15387	Y 850		
YA878 SS=E	449.2742(6)(a-c) Medication Administration NAC 449.2742 6. Except as otherwise provided in this	YA878		

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YA878	Continued From page 7 subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. This Regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications and or comply with physician orders for 2 of 6 residents (#3 and #6). Findings include: Observation	YA878		

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YA878	Continued From page 8 Resident #3 On 07/31/08 in the afternoon, the medication basket contained supplies of 20 milligram tablets of Lisinopril and 145 milligram tablets of Tricor refilled on 07/25/08. Resident #6 On 07/31/08 in the afternoon, the medication basket contained a supply of 50 milligram tablets of Metoprolol. It's label indicated twice daily. Interview Resident #3 On 07/31/08 in the afternoon, Employee #1 indicated the Lisinopril was currently administered, but Tricor was not currently administered. Employee #1 was uncertain whether it was supposed to be administered or not. Resident #6 On 07/31/08 in the afternoon, Employee #1 indicated the Metoprolol was administered twice daily. Record Review Resident #3 The medication list dated 07/02/08 indicated Lisinopril 20 milligrams daily. The June 2008 medication administration record (MAR) denoted Lisinopril 20 milligrams daily. The July 2008 MAR failed to list Lisinopril 20 milligrams daily. The	YA878		

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YA878	Continued From page 9 facility failed to provide a physician's discontinuation order. The medication list dated 02/12/08 indicated Tricor 145 milligrams daily. The medication list dated 07/02/08 failed to list Tricor. The June 2008 MAR and July 2008 MAR failed to list Tricor. The facility had refilled the Tricor 145 milligrams daily prescription on 07/25/08 and received a clarification order on 08/01/08 for Tricor 145 milligrams daily. The facility failed to provide a physician's discontinuation order for Tricor dated between 02/12/08 and 07/31/08. Resident #6 A physician order dated 07/18/08 indicated Metoprolol 25 milligrams half tablet daily. The July 2008 MAR denoted Metoprolol 50 milligrams half tablet twice daily as of 07/19/08. The container's label indicated Metoprolol 50 milligrams twice daily. The facility received a clarification dated 08/04/08 interpreting the 07/18/08 order as Metoprolol 25 milligrams, half 50 milligram tablet daily. The July 2008 MAR indicated the resident was receiving twice the ordered dose. Severity: 2 Scope: 2	YA878		